STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175323	A. Building B. Wing	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anew Healthcare	412 E Walnut St Nortonville, KS 66060

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 35. The sample included five residents, with three residents reviewed for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). Based on observations, record review, and interviews, the facility failed to follow physician orders to implement preventative wound interventions for Resident (R) 1. On 06/09/25, Consultant GG assessed R1 for a left heel ulcer, ordered suspension boots, and directed staff to clean the wound daily. Staff were to call the provider if the resident's left heel ulcer opened. The facility failed to input the order for suspension boots into R1's Electronic Medical Record (EMR) and further failed to implement the order or apply boots to R1's left heel. A wound assessment on 06/18/25 revealed the resident's left heel wound had opened up, and R1's EMR lacked evidence the facility had notified the resident's physician. The facility's failure to implement physician-ordered interventions to prevent worsening of R1's left heel wound resulted in a decline in the status of the wound, development of an additional wound, and R1 requiring the use of a wound vac (treatment method that uses suction to promote healing in complex wounds).Findings included:- R1's EMR documented diagnoses of diastolic congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid), pressure ulcer of the left heel, diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), and dementia (a progressive mental disorder characterized by failing memory and confusion) with agitation.The Quarterly Minimum Data Set (MDS) dated 06/13/25, documented R1 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderate cognitive impairment. R1 had impairment on one side of the lower extremities. R1 was independent rolling left and right. R1 required partial/moderate assistance for sitting up in bed. R1 had one deep tissue injury (DTI- purple or maroon localized area of discolored intact skin or blood filled blister due to damage of underlying soft tissue from pressure and/or shear) and open lesions other than ulcers, rashes, or cuts. The MDS documented R1 did not have a pressure-reducing device for chair, a pressure-reducing device for bed, was not on a turning/repositioning program, had no nutrition or hydration interventions to manage skin problems, pressure ulcer/injury care, surgical wound care, and required no application of ointments/medications other than to the feet. The MDS documented R1 required application of nonsurgical dressings to areas of the body other than to the feet and application of dressings to the feet.The Significant Change MDS dated 09/05/25, documented R1 had a BIMS score of five, which indicated severe cognitive impairment. R1 had impairment on one side of the lower extremities. R1 required supervision or touching assistance with rolling left and right. R1 had one stage one pressure injury (area which appears reddened, does not blanche, and may be painful but is not open) and one unstageable (depth of the wound is unknown due to the wound bed being covered by a thick layer of other tissue and pus) with slough (dead tissue, usually cream or yellow in color) and/or eschar (dead tissue) pressure ulcer. R1 had other open lesions on the foot. The MDS documented R1did not have a pressure-relieving device for the chair, a pressure-relieving device for bed, was not on a turning/repositioning program, lacked any nutrition or hydration intervention to manage skin problems, surgical wound care, and application of nonsurgical dressings other than to feet. The MDS documented R1 required application of ointments/medications to areas of the body other than to the feet, and application of dressings to the feet (with or without topical medications).The Functional Abilities CAA dated 09/05/25, documented R1 experienced a decline in activities of daily living (ADL) function.The Pressure Ulcer/Injury CAA dated 09/05/25, documented staff assessed the location, size, stage, presence of drainage, presence of odors, condition of skin, and if eschar or slough was present to the resident's wound. R1's Care Plan dated 09/26/24, documented R1 was at risk for skin issues related to incontinence, impaired mobility, and DM.The Care Plan documented interventions, dated 09/26/24, that directed staff to follow facility protocols for treatment of injuries. The plan directed staff to identify and document potential causal factors of wounds and eliminate/resolve those factors where possible. The plan revealed staff would monitor/document location, size, and treatment of skin injuries and reported abnormalities, failure to heal, and signs/symptoms of infection to the resident's doctor.The Care Plan documented an intervention, dated 10/06/24 that was revised on 02/04/25, that directed staff to know R1 had a pressure-reducing mattress and he required substantial assistance from staff for turning/repositioning. The plan documented an intervention, dated 01/02/25 and revised on 02/04/25, that directed R1 had a cushion in his wheelchair, and he was able